tions or favourable reference may be crucial in obtaining a partnership) by giving a low score or writing unpleasantly honest comments about the trainer and his practice. Even though trainers do not receive the scores and comments until some months after a trainee has left, the trainee is still likely to be seeking a permanent position.

As an ex-trainee of the Northumbria vocational training scheme I was aware that several of my colleagues felt that trainers could identify an individual ex-trainee from trainees' comments on the anonymous questionnaires and therefore it would not have been surprising if trainees played safe and marked generously.

The other factor that supports my doubts about the validity of this method of assessment is that there was no significant change in the scores between the first and second 18-month periods. If the intention of this exercise was to improve the standards of trainers and their practices, then it failed either because no improvement occurred or because the method of assessment was not objective enough to detect improvement.

PHILIPPA WOOD

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Sir,

Dr Wood's letter criticizes our method of assessment of teaching practices on the grounds of possible bias from self-interest. This risk is one that we are well aware of and we would accept Dr Wood's comments without reservation.

Trainees may refrain from unpleasant criticism of their trainers for a variety of reasons including the one stated by Dr Woods. Another common reason is that trainees and trainers like each other, and trainees' comments suggest that this is often the case. However, as we pointed out, trainees do sometimes make unflattering comments and give scores to match so that at least some are not motivated by self-interest.

Many trainers feel confident that they can identify the individual trainee whose comments are fed back to them but surprisingly they are often wrong when this is put to the test. In any case it is one thing to suspect an identity and another thing to prove it.

Furthermore, although there have been no significant changes in the scores of the Northumbria teaching practices as a whole there have been some very significant changes in individual practices — even to the extent of a change in the identity of the trainer.

Clearly our method has both advantages and limitations, and as we suggested it should be supplemented by other methods of assessment and feedback. Our method is, however, simple, cheap, easy to administer and a useful educational exercise.

I. AIRLIE

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Sir,

The paper by Drs Charlewood and Airlie is interesting but not very helpful. The criteria used for assessment are no doubt characteristics of 'good doctors' but the talents required by trainers and training practices are different in my opinion.

While it is helpful for me as a trainee to be attached to a practice with good relationships between all staff, good premises and organization and a high standard of medicine, what matters most to me is much less tangible and to do with broadening my horizons as a person and as a doctor.

I would suggest adding to the criteria of a good trainer the following:

1. Does he/she encourage me to think broadly about health issues and challenge established dogma?
2. Does he/she identify my weaknesses and help me to develop my talents?
3. Does he/she give me time and space to criticize and comment on the practice in particular and medicine in general?
4. Does he/she listen to me?
5. Does he/she introduce me to new ideas and to a variety of paramedical people to allow me to understand the complexity of health problems?

We live in times of rapid change and yesterday's concepts of ideal health care do not answer today's needs. We need doctors to be inspired, questioning and humble, to develop the ability to challenge and improve our health care system while taking note of what is said by many others. It should be a priority of trainers to promote such abilities in trainees and they should be judged according to how well they fulfil this task.

I have one year as a trainee — one very very valuable year. At the end I have to ask of my trainers, 'Yes, they are good doctors — but did they make me think?'.

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Deputizing services

Sir,

Why is Dr Smith so concerned about 30% of training practices using deputizing services? (Letters, March *Journal,* p.131). It is generally considered that out-of-hours work comprises less than 2% of the total workload in general practice. A well-run deputizing service will provide a service at least as good as an average rota.

If Dr Smith is concerned about continuity of care he should turn to the paper by Roland and colleagues (March *Journal,* p.102), where he will find that group practices, even those with personal lists, could do no better than a continuity score of 1.0 in 30% of cases (that is 30% of patients saw the same doctor at every consultation). As a single-handed practitioner I would be upset if I did not have a continuity score of 1.0 in 80% of cases!

Surely the answer to the problem of continuity of care is in the formation of consortia of single-handed doctors sharing premises and facilities rather than group practices or partnerships.

It is irritating for colleagues to be continually sniping at deputizing services in different ways often without any consideration of the great value that good services of this type provide for patients in need and for the relief of over-worked doctors.

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Personal lists

Sir,

Like your correspondents in the March edition of the *Journal* (p.133), I had read the leading article on personal lists by Dr Tant (November 1985 *Journal,* p.507). My only criticism at the time was that he had been too tactful in not emphasizing the dilution of personal care that must occur in combined list group practices.

The advantages to patients of being able to 'shop around' for an appropriate doctor for each ailment are more apparent than real. An articulate fraction of our patients will always have the ability to choose appropriate medical care and in a good personal list system patients should have the right to change their doctor without rancour. Those of our patients who really do need continuity of care (the inadequate, the mentally handicapped, the feckless, the eccentric and the unlikeable) are least likely to be able to choose which doctor they should consult about certain problems and in a combined list practice will probably be seen by whichever part-

ner happens to be available for each episode of illness. No one doctor will be charged with the responsibility for providing continuing primary care for a vulnerable individual and collective responsibility can so easily become the collusion of anonymity.

As general practitioners we are under threat from many quarters. The taxpayer would prefer to employ more ancillary staff at a quarter of our salaries to do 90% of our work, nurses and pharmacists feel they already do much of our job themselves, and hospitals are encroaching into general practice in every possible way with paediatric, geriatric, psychiatric, handicap, asthma and diabetic community teams. The general practitioner's unique role is to provide continuity of care in the context of family medicine. If we abdicate from that we have only ourselves to blame if others eventually decide that general practitioners have nothing extra to offer the care of the sick in the community apart from doing the night calls (where there is no deputizing service).

After reading the letters in the March *Journal,* I then turned to the original papers in the same issue. My eye was caught by the summary of the article by Roland and colleagues (March *Journal,* p.102). It stated: 'Patients registered with practices operating personal lists received much better continuity of care than those registered with practices operating combined lists. Patients...regarded continuity of care as important, especially if they were registered with practices operating personal lists'.

I suggest that combined list practices have little advantage for patient care over personal lists and it is only doctors who benefit from them.

CLIVE RICHARDS

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Sir,

I was surprised that Dr Elliott-Binns (Letters, March *Journal,* p.134) listed so many disadvantages of the personal list system. In practices with partners of different ages the methods of treatment of different conditions, for example hypertension, are often totally different; with Dr Elliott-Binns system of pooling patients the younger practitioners may not be familiar with the side-effects of methyldopa and similarly the elder practitioner may not be familiar with the side-effects of calcium antagonists.

Dr Elliott-Binns also suggests that personal lists decrease the doctor's awareness of his partners' ways of working but he forgets that in most partnerships night visits, evening visits and weekend work is usually discussed by the visiting doctor and it is without doubt better for the patient that the duty doctor has a specific doctor to inform about a patient's progress. This will lead to the discussing of patients which Dr Elliott-Binns fears would not happen with a personal list system. The beauty of the personal list system is that chronic problems and chronic patients do not get passed from one doctor to another, but doctors are made responsible for the proper treatment of their patients. With a personal list system it soon becomes apparent if a doctor has a weakness, as other partners are constantly picking up that problem at night or at weekends. This leads to a superb peer review system, and a stimulus for the doctor to brush up his weak subjects.

Dr Elliott-Binns makes the point that patients are unable to sample or choose their doctors, but on the other hand it is well-known that many patients will 'hunt' the general practitioner who will give them the treatment they perceive they need. It may be better for the patient to be told to take aspirin for a sore throat rather than to make appointments with each doctor in the practice on separate days until he is prescribed the penicillin he perceives he needs. If the patient can only turn to one doctor he will always get the same drugs and the same treatment and will learn to respect and understand that doctor's working methods.

Finally, I would agree with Dr Elliott-Binns' comment that sometimes one particular doctor is busier than the others. This does tend to equal out over the year, and the advantage is that the busy doctor cannot shirk his own patients. If they are his patients he has to see them. It is all too easy in a busy partnership for each doctor to invent excuses not to see any 'extras'.

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Medical record folder for the Lloyd George envelope

In January 1965 I took over a practice from a single-handed practitioner and was immediately faced with the task of keeping clinical records to satisfy my needs. I felt that a summary card was needed and I plagiarized the idea of a folder from the Birmingham practice where I had previously been an assistant. The redevelopment of Aston had caused the NHS list of Dr Roger Morgan to have a high turnover and I adopted his solution to the problem of summarizing clinical information about large numbers of new patients. This solution had some features in common with the record folder proposed by Drs Floyd and White (January *Journal,* p.19). I shall call Dr Morgan's design the 'Aston' folder and Dr Floyd's design the 'Croydon' folder.

The folder acts as a cover for the contents of each medical record envelope (FP5/FP6). The material and dimensions are critically important; the most suitable material is index board which resists wear and tear at the fold for much longer than cheaper, softer papers. At the same time the surface is not too highly glazed to be written on conveniently. I use a card of the same height as the Croydon folder (177 mm) as this is the height of the English forms FP7 and FP8. NHS stationery is not standardized and there is considerable variation between different print orders by the DHSS. Present continuation cards do not fit envelopes FP5 and FP6 which are 2 or 3 mm shorter and, because of the thickness of the cards, the internal dimension loses a further 2 mm or so. Both the folder and FPs 7 and 8 therefore project some 5 mm, with resultant wear on the top edges. The Aston folder is a few millimetres wider than the Croydon folder which allows it to enclose the whole contents of the envelope and to slip easily in and out of the envelope for each consultation. I have found in a short trial of treasury tags that there was excessive wear on records and that mounting pages on tags caused avoidable extra work for both ancillary staff and doctors.

I am also concerned that the Croydon folder carries so much sensitive and confidential information on its outside pages.

Dr Floyd uses the second page of the record card to create a dated biography. While this has points in its favour, it is very wasteful of space for the majority of patients. It may show clusters of life events but it may be just as relevant to show clusters of organ or regional events. In 1964, Dr Morgan devised a graphic way of overcoming the list presentation by printing an outline anatomical figure on page two of the Aston folder. This figure enables clinical events from fractures to fugue-like states to be entered in relation to regions, by side and by site, and enables the many scars on some abdomens to be clearly identified. The addition of a simple detail here and there will easily distinguish internal events. This minimal structure allows great flexibility of recording and has been readily adapted to patients' needs over long periods.